FUNDING APPROVAL REQUEST **PRIMARY CHILD:** ______________________________ (9/08)

PLEASE COMPLETE FOR EACH QUARTER AND AS NEEDED (7/1-9/30, 10/1-12/31, 1/1-3/31, 4/1-6/30)

Current Quarter: Begin Date: ____________ End Date: ______________ ☐ **NO CHANGE** (Please include Vendor(s), Services, and Monthly Amount)

Vendor	Current License Verified[1]	Service	Special Ed. IEP Service[2]	IV-E Funded Service[3]	Communit y Trans. Svec[4]	Home/Comm. – Family[5]	Unit Type	Rate Per Unit	Units Per Month	Monthly Cost	Services Expected Begin Date	Services Expected End Date
								$		$		
								$		$		
								$		$		
								$		$		
								$		$		
								$		$		
FAPT Approval Status:					**Total Monthly Amount: $**							

ADDITIONS/CHANGES DURING CURRENT QUARTER

Vendor	Current License Verified[1]	Service	Special Ed. IEP Service[2]	IV-E Funded Service[3]	Community Trans. Svec[4]	Home/Comm. – Family[5]	Unit Type	Rate Per Unit	Units Per Month	Monthly Cost	Services Begin Expected Date	Services Expected End Date
								$		$		
								$		$		
								$		$		
								$		$		

Additional Changes Total Monthly Amount: $

Combined Total Monthly Amounts: $

[1] Verification of current license is needed for all providers where certification or license is required. (A copy of the license/certification is required for IV-E Foster Care funded services.)

SUPERVISOR OR CPMT DESIGNEE MUST INTIAL ALL ADDITIONS OR CHANGES

Is a FAPT required based on additions/changes? ☐ **Yes** ☐ **No** **If yes, give FAPT approval status:** __________________

Is a FAPT required based on additions/changes? ☐ **Yes** ☐ **No** **If yes, give FAPT approval status:** __________________

[2] **Special Ed IEP Service:** Is this service included on youth's IEP? (Indicate Y or N) [3] **IV-E Funded Service:** Is this a IV-E eligible service? (Indicate Y or N)

[4] **Community Trans Svc:** Is this a service provided directly to family (e.g. parent, relative, or foster family) to prepare them for child's transition to the home from residential care? (Indicate Y or N)

[5] **Home/Comm. - Family:** Is this a service provided directly to the child and/or biological/extended/or adoptive family and delivered in the family's home or home community? (Indicate Y or N)